

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH


NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.



Director, Program Policy Division  
Bureau of Policy and Federal Affairs  
Medical Services Administration

<b>Project Number:</b>	0352-HAD	<b>Comments Due:</b>	11/7/03	<b>Proposed Effective Date:</b>	January 1, 2004
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**Policy Subject:** Hearing Aid Dealer Coverages and Limitations Chapter

**Affected Programs:** Medicaid, Children's Special Health Care Services

**Distribution:** Hearing Aid Dealers

**Policy Summary:** This bulletin transmits a revised Hearing Aid Dealer Coverages and Limitations Chapter (formerly known as Chapter III). The chapter incorporates bulletins issued since the last Chapter III revision. Policy changes and clarifications are included. The chapter becomes effective on January 1, 2004 for services provided to beneficiaries under age 21 only. Hearing Aid Dealer services are not currently a benefit for beneficiaries age 21 and over.

# Proposed Policy Draft

Michigan Department of Community Health  
Medical Services Administration

**Distribution:** Hearing Aid Dealers

**Issued:** December 1, 2003 (proposed)

**Subject:** Hearing Aid Dealer Coverages and Limitations Chapter

**Effective:** As Indicated

**Programs Affected:** Medicaid, Children's Special Health Care Services

This bulletin transmits the revised Hearing Aid Dealer Coverages and Limitations Chapter. As part of the chapter revision process, previously issued policy bulletins have been incorporated. Rewording and clarification of existing policy, as well as policy changes have been included to reflect issues raised and clarifications requested by the provider community and from within the Michigan Department of Community Health (MDCH). In addition, the revisions to this chapter further refine the uniform billing project goal of consistency between Medicaid and other payers.

Hearing Aid Dealer services are not currently a benefit for beneficiaries age 21 and over and will continue to be non-covered until funding is restored and a bulletin is distributed notifying providers of the effective date of coverage. The attached chapter becomes effective on January 1, 2004 for beneficiaries under age 21 only.

In reviewing this chapter, please note the following:

- Reorganization of information to include "Standards of Coverage", "Prior Authorization Requirements" and "Payment Rules" sections for each major service area.
- Hearing aids have been defined for purposes of administering and clarifying Medicaid coverage.
- Changes in prior authorization criteria for digital/programmable hearing aids.



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## INTRODUCTION

The primary objective of the Medicaid Program is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services, recommended and supported by a pediatric sub-specialist, with care coordination that relates to the CSHCS qualifying diagnosis. Policies are aimed at maximizing the health care services obtained for this population with the limited number of dollars available.

The term "Medicaid" throughout this chapter refers to both the Medicaid Program and the CSHCS Program.

## PROVIDER LICENSURE REQUIREMENT

Services must be provided by a Medicaid-enrolled hearing aid dealer licensed in the state of Michigan and must conform to the standards of practice described in the current Michigan Occupational Code (Act 299 of 1980, Article 13).

## HCPCS CODES AND PARAMETERS

For specifics regarding Medicaid coverage of the Health Care Financing Administration Common Procedure Coding System (HCPCS), refer to the Hearing Aid Dealers Database on the MDCH website at [www.michigan.gov/mdch](http://www.michigan.gov/mdch). To access this database, first click on "Providers", next click on "Information for Medicaid Providers", and then "Medicaid Fee Screens". The database includes the HCPCS code, short description, current activity status, fee screens, quantity limits, prior authorization (PA) indicator, and age limits.

If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code. All NOC codes require prior authorization.

## HCPCS MODIFIERS

The "LT" or "RT" modifiers must be reported for all monaural hearing aids, hearing aid repairs/modifications and earmolds to designate either the left or right side of the body.

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## COVERED SERVICES

Medicaid covers the following services when provided by a licensed hearing aid dealer:

- Hearing aids and delivery
- Hearing aid repairs and modifications
- Replacement earmolds
- Hearing aid supplies and accessories
- Replacement of hearing aid batteries
- Alternative listening devices for beneficiaries over age 21 years

## NON-COVERED ITEMS

Non-covered items include, but are not limited to, the following:

- Hearing aids that do not meet U.S. Food and Drug Administration and Federal Trade Commission requirements
- Spare equipment (e.g., an old hearing aid in working condition for back-up use in emergencies)
- Personal FM Amplification Systems
- Alerting devices
- Hearing aids requested solely or primarily for the elimination of tinnitus
- Equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics
- Hearing aids delivered more than 30 days after a beneficiary becomes ineligible for Medicaid

## MANDATORY HEARING AID MANUFACTURER'S WARRANTY

Medicaid requires that all hearing aids must include a manufacturer's warranty that guarantees replacement of a lost, broken or stolen hearing aid one time within the first 12 months after the hearing aid is dispensed. This guarantee must be provided at no cost to the beneficiary or to Medicaid.

## CO-PAYMENTS

Beneficiaries are required to pay a \$3.00 co-payment for a hearing aid. Exceptions to the co-payment include:

- Medicaid beneficiaries under age 21
- All CSHCS beneficiaries
- All beneficiaries residing in a long-term care facility

If a beneficiary is unable to pay a required co-payment on the date of service, the provider CANNOT refuse to render the service. The provider may bill the beneficiary for the co-payment amount, and the beneficiary is responsible for paying it. If the beneficiary fails to pay a co-payment, the provider could, in the future, refuse to serve the beneficiary.

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When calculating reimbursement, Medicaid will deduct the co-payment from the amount billed when applicable. If the provider deducts the co-payment from his/her claim, an underpayment will result. Addition of the co-payment amount to the acquisition cost is not allowed.

## **DISPENSING FEE**

The hearing aid dealer may only bill the dispensing fee when providing direct patient contact in delivering and instructing the beneficiary on the use and care of the hearing aid. The dispensing fee is billed separate from the hearing aid using the appropriate HCPCS code. Components of the dispensing fee are not to be billed separately. Reimbursement for the hearing aid dispensing fee includes, but is not limited to:

- Hearing aid delivery
- Modification and adjustments required within the manufacturer's warranty period
- Fitting, orientation and checking of the hearing aid
- Instructions on use and care of the hearing aid
- Initial earmolds and impressions
- All necessary components that may include cords, tubing, connectors, receivers and huggies
- One standard package of appropriate batteries per aid (or charger for rechargeable models)
- One year warranty on parts and labor repairs
- A minimum 30-day trial/adjustment period with exchange/return privilege

## **MEDICAL CLEARANCE**

A medical clearance is a signed statement from the physician indicating that:

- a medical evaluation has been performed
- a hearing aid is medically necessary
- there are no contraindications to the use of a hearing aid

For Medicaid beneficiaries under age 18, an otolaryngologist must complete the medical clearance.

For Medicaid beneficiaries age 18 years or older, the medical clearance may be completed by either an otolaryngologist or the primary care physician.

The medical clearance must include the beneficiary's name, birth date, address, Medicaid ID number, the services provided, the date of service, the provider's name and Medicaid provider ID number.

## **DOCUMENTATION IN BENEFICIARY FILE**

The hearing aid dealer must maintain all applicable documentation in the beneficiary's file for six years. For audit purposes, the hearing aid dealer's records or patient's medical record must substantiate the medical necessity of the item supplied.

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## MEASURABLE BENEFITS/HEARING AID CONFORMITY CHECK

The hearing aid dealer must instruct the beneficiary to return to the hearing and speech center for the conformity evaluation during the 30-day trial period. Any delivered hearing aid(s) is expected to demonstrate measurable benefit, established either at the time of fitting or follow-up. Benefit may be established by any one of, or a combination of, commonly used procedure(s), including measures of aided hearing and understanding of speech; functional gain measures; probe-microphone measurements, and/or (minimally) the subjective impressions of the beneficiary, the beneficiary's family member(s) or guardian, or attending staff. Benefit may be demonstrated in cases of severe to profound hearing loss by one of, or a combination of, the following measures:

- improved functional or insertion gain in the speech frequencies
- increased awareness of speech and/or environmental sounds
- improved speech recognition performance at average or slightly raised conversational levels with or without visual cues
- beneficiary's or family members' subjective report of speech benefit in everyday listening situations

When a delivered hearing aid does not provide benefit, as defined above, the provider is expected to return it to the manufacturer within 30 days for circuitry modifications, remake, exchange, or credit, as recommended by the Type 80 audiologist. The hearing aid dealer must notify the beneficiary of this when the hearing aid is dispensed.

All full or partial refunds made by a manufacturer to the hearing aid dealer when a hearing aid is returned within the 30-day trial period and replaced with a less costly aid must be returned to Medicaid via a claim replacement.

## PRIOR AUTHORIZATION

Prior authorization is required for certain services before the services are rendered. To determine which services require prior authorization, refer to the "Standards of Coverage, Limitations and Payment Rules" Section of this Chapter or the Hearing Aid Dealers Database on the MDCH website.

### Prior authorization will be required for the following situations:

- All hearing aids, except conventional analog hearing aids meeting the bilateral standards of coverage
- Alternative Listening Devices
- Services and items that exceed quantity limits, frequency limits, or established fee screen
- For a Not Otherwise Classified (NOC) code

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## **PRIOR AUTHORIZATION (PA) FORM AND COMPLETION INSTRUCTIONS**

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B). Medical documentation (e.g., medical clearance, audiogram and hearing aid recommendation from audiologist, documentation to substantiate the acquisition cost) must accompany the form. A copy of the form is available on the MDCH website. The information on the PA request form must be:

- **Typed** – All information must be clearly typed in the designated boxes of the form
- **Thorough** – Complete information, including manufacturer, model and style of the hearing aid requested, and the appropriate HCPCS procedure codes with applicable modifiers must be provided on the form. The form and all documentation must include the beneficiary name and Medicaid ID number, provider name, address and Medicaid provider ID number.

PA request forms for all eligible Medicaid beneficiaries must be sent or faxed to the following address:

Department of Community Health  
Review and Evaluation Division  
P.O. Box 30170  
Lansing, Michigan 48909

FAX: 517- 335-0075

To check the status of a prior authorization request, call 800-622-0276.

### **Form Completion Instructions**

The following instructions for the Special Services Prior Approval-Request/Authorization Form (MSA-1653-B) are self-explanatory. Special instructions are noted, when necessary. It is mandatory to complete boxes 12 through 39. For complete information on required modifiers, documentation, and appropriate quantity amounts, please refer to the following documents:

- Hearing Aid Dealer Coverages and Limitations Chapter, Section 2 - Standards of Coverage, Limitations and Payment Rules
- Billing and Reimbursement Chapter
- Hearing Aid Dealers Database on the MDCH website

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<b>Boxes 1. Through 10. – MDCH use only.</b>		<b>AL SERVICES REQUEST/AUTHORIZATION</b> Department of Community Health		<b>Box 11. – MDCH Prior Authorization Number</b>							
<b>NOTE: APPROVAL REFERS TO SERVICE AND DOES NOT GUARANTEE RECIPIENT ELIGIBILITY.</b>		<b>CONSULTANT USE ONLY</b>									
		2.	3.	4.	5.	6.	7.	8.	9.	10.	11. Prior Authorization No.
12. Provider	<b>Boxes 12 Through 14., 16. &amp; 17. – Provider Name, Type, Provider ID Number, Address and Phone Number</b>			13. Type	14. ID Number			15. Provider Use Only			
16. Provider							<b>Box 15. – Provider Use Only</b>				
18. Recipient's Name (Last, First, Middle Initial)				19. Sex	20. ID Number			21. Birth Date		22. County	
23. Recipient's				<b>Boxes 18. Through 23.- Beneficiary Name, Sex, ID Number, DOB, County of Residence, and Address</b>			24. Does Patient Reside in a Nursing Care Facility <input type="checkbox"/> YES <input type="checkbox"/> NO				
25. Referring P				26. Type	27. ID Number			28. Phone Number			
29. Referring Physician's Address (Number, Street, City, State, Zip)											
30. Line No.	31. DESCRIPTION OF SERVICE (Include brand name and model number where applicable)	32. Procedure Code	33. Qual	34.	35.	<b>Box 24 – Check Yes if beneficiary is in NF or No if the beneficiary is not in an NF. Provide NF Address and Phone Number in Box 37</b>					
01	<b>Boxes 25. Through 29. – Referring provider name, Type, Medicaid ID Number, Phone Number and Address</b>										
02											
03	<b>Box 31.-Enter a complete description, including manufacturer, model and style of hearing aid requested.</b>					<b>Box 32.-Enter the HCPCS procedure code.</b>					
04											
05						<b>Box 35.-Enter the applicable HCPCS modifier</b>					
36. Primary Diagnosis Description and Prescription (Quote Physician Order)						37. Remarks and/or Documentation of Medical Necessity					
<b>Box 36. –Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description).</b>						<b>Box 37. –Any additional remarks regarding the request should be listed in this box such as NF Name , Address, and Phone Number, verbal authorization date, retroactive date of service if being requested, etc.</b>					
38. Indicate Any Other Services Provided To This Recipient During the Past Year											
39. PROVIDER CERTIFICATION: The patient named above (parent if minor or authorized representative) understands the necessity to request prior approval for the services indicated in Item 31. I understand the services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of the bill and that any false claims, statements or documents or concealment of a material fact may be prosecuted											
<b>Box 40. If amended, a change has been made on the form.</b>											
Date											
<b>CONSULTANT USE ONLY</b>											
40. APPROVED AS: PRESENTED <input type="checkbox"/> AMENDED <input type="checkbox"/>	41. DISAPPROVED <input type="checkbox"/> NO ACTION <input type="checkbox"/> INSUFF. DATA <input type="checkbox"/>	42. <b>Box 42 –The MDCH Consultant signature.</b>									
		Consultant Signature									
		Date									
MSA-1653-B											
<b>Box 41. –If No Action, returned because beneficiary is in an HMO, service does not require PA, etc. If Insuff. Data, returned for more information.</b>											

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## **EMERGENCY PRIOR AUTHORIZATION**

A provider may contact the Department to obtain a verbal prior authorization when the physician providing the medical clearance has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain verbal prior authorization, the provider may call or fax a request. If the provider faxes a request, the request must state, "verbal prior authorization required" and indicate the physician name and phone number in box #37 on the MSA-1653-B.

Contact Information:

Review and Evaluation Division  
Phone: 1-800-622-0276 (Weekdays, 9:00 a.m. to 4:00 p.m.)  
FAX: 517-335-0075

If a service is required during non-working hours (i.e., after 4:00 p.m., weekends and State of Michigan holidays), the provider must contact the Review and Evaluation Division the next working day.

The following steps must still be completed before a PA number is issued for billing purposes:

- The prior authorization request form MSA-1653-B must be submitted to the Review and Evaluation Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted along with the prior authorization request.
- The verbal authorization date must be entered in box #37 of the MSA-1653-B.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible when the service was provided.
- The completed prior authorization request (MSA-1653-B) and required documentation are not received by the Review and Evaluation Division within 30 days of the verbal authorization.
- The required documentation is dated after the date of service.

## **RETROACTIVE PRIOR AUTHORIZATION**

Services provided before prior authorization is requested will not be covered unless the beneficiary was not eligible on the date of service and a subsequent eligibility determination was made retroactive to the date of service. If the Department's record does not show that retroactive eligibility was provided, then the request for retroactive prior authorization will be denied.

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## **BENEFICIARY ELIGIBILITY**

Approval of a service on the Special Services Prior Approval-Request/Authorization (MSA-1653-B) confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible. To assure payment, the provider must verify eligibility for “Fee For Service” Medicaid or the CSHCS Programs before initiating services.

## **REIMBURSEMENT AMOUNTS**

Many items have established fee screens that are published in the Hearing Aid Dealers database. For Not Otherwise Classified (NOC) codes and all codes without established fee screens, the approved reimbursement amount will be indicated on the authorized PA request.

## **BILLING AUTHORIZED SERVICES**

After authorization is issued, the information (e.g., prior authorization number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the claim form. Refer to the Billing and Reimbursement Chapter for complete billing instructions.

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## HEARING AIDS-GENERAL

### DEFINITIONS

The following definitions are to be used for purposes of administering and clarifying Medicaid coverages and limitations for hearing aid dealers:

#### Hearing Aid-

A hearing aid, also referred to as a hearing instrument, is an electronic device that brings amplified sound to the ear. The hearing aid usually consists of a microphone, an amplifier and a receiver.

#### Conventional Analog Hearing Aid-

An amplification device that uses conventional, continuously varying signal processing. Includes hearing aids that are body worn, behind the ear, in the ear, in the canal and bone conduction. Does not include any hearing aid considered digitally programmable or CROS/BICROS circuitry.

#### CROS Hearing Aid-

Contralateral routing of signal. A hearing aid with a microphone worn on an unaidable ear with a receiver worn on the better ear. The receiver cannot be worn alone.

#### BICROS Hearing Aid-

Bilateral routing of signal. A hearing aid with microphones worn on each ear with a receiver on the better ear.

#### Programmable Hearing Aid-

Digitally-controlled analog or digital signal processing hearing aid in which the parameters of the instrument are under computer control.

#### Digital Hearing Aid-

A hearing aid that processes signals digitally (syn:DSP).

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## STANDARDS OF COVERAGE FOR ALL HEARING AIDS

Hearing aids are a benefit for beneficiaries of all ages when:

- The recommended hearing aid meets U.S Food and Drug Administration and Federal Trade Commission requirements
- Medical documentation indicates that the hearing loss is not temporary in nature due to a treatable medical middle ear effusion or that surgery is not planned until at least a year into the future for a conductive type hearing loss
- No hearing aid has been dispensed to the beneficiary within three years
- The hearing aid includes a mandatory hearing aid manufacturer's warranty

## CONVENTIONAL ANALOG HEARING AIDS

### STANDARDS OF COVERAGE E-BILATERAL HEARING LOSS

**Age Under 21 Years**, the bilateral hearing loss standards of coverage for a conventional analog monaural or binaural hearing aid are as follows:

- Bilateral hearing loss documented by an audiogram showing hearing loss of 25 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000 and 4000 Hz **OR**
- Results of a complete diagnostic audiological evaluation (e.g., auditory brainstem response, evoked otoacoustic emissions, soundfield testing, or any combination of these) indicating a hearing loss of 25 dB HL or greater

**Age 21 Years or Over**, the bilateral hearing loss standards of coverage for a conventional analog **monaural** hearing aid are as follows:

- Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz
- A speech recognition score of at least 20% in the ear to be aided

**Age 21 Years or Over**, the bilateral hearing loss standards of coverage for conventional **binaural** hearing aids are as follows:

- Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000, and 4000 Hz
- A speech recognition score must be greater than 20% in both ears
- The four frequency average between ears must not exceed 20dB HL
- The speech recognition scores must not differ between ears by more than 30%

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## **STANDARDS OF COVERAGE-UNILATERAL HEARING LOSS**

**Age Under 21 Years**, the unilateral hearing loss standards of coverage for a conventional analog hearing aid are as follows:

- Hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear
- Speech recognition scores must be greater than 60% in the ear to be aided
- The beneficiary must be receiving hearing impaired services through the school system
- A 30-day trial has been completed and indicates that amplification has been accepted and that auditory skills and learning capacity were enhanced OR there is a documented history of prior hearing aid use

**Age 21 Years or Over**, the unilateral hearing loss standards of coverage for a conventional analog hearing aid are as follows:

- Hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear
- Speech recognition scores must be greater than 60% in the ear to be aided
- A Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit or similar inventory indicates a need for amplification
- Hearing aid is required for independent functioning (e.g. affects on employment, communication status)

## **DOCUMENTATION**

Applicable documentation includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid
- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and charges

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Applicable documentation also includes the following when a conventional analog hearing aid is dispensed for unilateral hearing loss:

#### **Age Under 21 Years**

- An audiogram documenting hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear
- Documentation of speech recognition scores greater than 60% in the ear to be aided
- Documentation from the educational system that the child is receiving hearing impaired services
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial OR a documented history of prior hearing aid use

#### **Age 21 Years or Over**

- An audiogram documenting hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear
- Documentation of speech recognition scores greater than 60% in the ear to be aided
- Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit or similar inventory indicating need for amplification
- Documentation of requirement for independent functioning (e.g., affects on employment, communication status)

### **PRIOR AUTHORIZATION REQUIREMENTS**

PA is not required for either monaural or binaural conventional analog hearing aids if the bilateral standards of coverage are met.

PA is required for the following:

- Replacement aids within 3 years
- Conventional analog hearing aids when the bilateral standards of coverage are not met
- Conventional analog hearing aids for unilateral hearing loss

The following documentation must be submitted with all prior authorization requests:

- MSA-1653-B
- Copy of the manufacturer's invoice showing invoice price, discounts, and shipping and handling charges
- Medical clearance signed by a physician
- Audiogram completed within the past 6 months, signed and dated by the audiologist and including the recommended manufacturer, model and style

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#### Unilateral Hearing Loss-

The following additional documentation must be submitted with all prior authorization requests for conventional analog hearing aids provided for unilateral hearing loss:

##### Age Under 21 Years

- An audiogram documenting hearing loss of 25 dB HL or greater in the ear to be aided, with normal hearing in the better ear
- Documentation that the ear to be aided has a speech recognition score greater than 60%
- Documentation provided by the educational system that the child is receiving hearing impaired services
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired, and/or the educational audiologist that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial OR documentation of a history of prior hearing aid use

##### Age 21 Years or Over

- An audiogram documenting hearing loss of 30 dB HL or greater in the ear to be aided with normal hearing in the better ear
- Documentation that the ear to be aided has a speech recognition score greater than 60%
- Results of administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating a need for amplification
- Documentation of requirement for independent functioning (e.g., affects on employment, communication status)

## PAYMENT RULES

Payment for a conventional analog hearing aid will be the lesser of the provider's acquisition cost or Medicaid's maximum allowable amount. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

## CROS HEARING AIDS

### STANDARDS OF COVERAGE

CROS hearing aids are a benefit for beneficiaries of all ages when:

- There is demonstrated need for amplification
- An audiogram indicates no residual hearing in the poorer ear (unaidable) and normal hearing in the better ear as demonstrated by thresholds less than 30 dB HL using the four frequency average of 500, 1000, 2000, and 4000 Hz.

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**Age Under 21 Years**, the standards of coverage for CROS hearing aids are as follows:

- The beneficiary must be receiving hearing impaired services through the school system
- A 30-day trial has been completed and indicates that amplification has been accepted and that auditory skills and learning capacity were enhanced OR there is a documented history of prior CROS hearing aid use

**Age 21 Years or Over**, the standards of coverage for CROS hearing aids are as follows:

- A Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicates a need for amplification
- Hearing aid is required for independent functioning (e.g., affects on employment, communication status)

## **DOCUMENTATION**

Applicable documentation for CROS hearing aids includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid
- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts and shipping charges
- Documentation of need for amplification addressing beneficiary's communication needs

Applicable documentation for CROS hearing aids also includes the following:

### **Age Under 21 Years**

- Documentation from the educational system that the child is receiving hearing impaired services
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial OR documentation of a history of prior CROS hearing aid use

### **Age 21 Years or Over**

- Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating need for amplification.
- Documentation of requirement for independent functioning (e.g., affects on employment, communication status).

## **PRIOR AUTHORIZATION REQUIREMENTS**

PA is required for all CROS hearing aids.

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The following documentation must be submitted with all prior authorization requests for CROS aids:

- MSA-1653-B
- Copy of the manufacturer's invoice showing invoice price, discounts, and shipping and handling charges
- Medical clearance signed by a physician
- Audiogram completed within the past 6 months, signed and dated by the audiologist and including the recommended manufacturer, model and style. The audiogram must indicate no residual hearing in the poorer ear (unaidable) with normal hearing in the better ear as demonstrated by thresholds less than 30 dB HL using the four frequency average of 500, 1000, 2000, and 4000 Hz.

The following additional documentation must be submitted with all prior authorization requests for CROS hearing aids:

#### **Age Under 21 Years**

- Documentation from the educational system that the child is receiving hearing impaired services
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist stating that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial

#### **Age 21 Years or Over**

- Results of the administration of the Hearing Handicap Inventory for the Elderly, Hearing Handicap Inventory for Adults, Adult Performance Hearing Aid Benefit, or similar inventory indicating need for amplification
- Documentation of requirement for independent functioning (e.g. affects on employment, communication status)

### **PAYMENT RULES**

Medicaid's payment for a CROS hearing aid will be the lesser of the acquisition cost or Medicaid's maximum allowable amount. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

## **BICROS HEARING AIDS**

### **STANDARDS OF COVERAGE**

BICROS hearing aids are a benefit for beneficiaries of all ages when there is demonstrated need for amplification.

**Age Under 21 Years**, the standards of coverage for BICROS hearing aids are as follows:

- An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 25 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear

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**Age 21 Years or Over**, the standards of coverage for BICROS hearing aids are as follows:

- An audiogram indicates no residual hearing in the poorer ear (unaidable) and indicates a hearing loss greater than 30 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear
- Hearing aid is required for independent functioning (e.g., affects on employment, communication status)

## DOCUMENTATION

Applicable documentation for BICROS hearing aids includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid
- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts and shipping charges
- Documentation of need for amplification addressing beneficiary's communication needs

Applicable documentation also includes the following when BICROS hearing aids are dispensed to beneficiaries **Age 21 Years or Over**:

- Documentation of requirement for independent functioning (e.g. affects on employment, communication status)

## PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all BICROS hearing aids.

The following documentation must be submitted with all prior authorization requests for BICROS hearing aids:

- MSA-1653-B
- Copy of the manufacturer's invoice showing invoice price, discounts, and shipping and handling charges
- Medical clearance signed by a physician
- Audiogram completed within the past 6 months, signed and dated by the audiologist, and including the recommended manufacturer, model and style.

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The following additional documentation must be submitted with all prior authorization requests for BICROS hearing aids:

#### **Age Under 21 Years**

- The audiogram must indicate no residual hearing in the poorer ear (unaidable) and a hearing loss greater than 25 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear

#### **Age 21 Years or Over**

- The audiogram must indicate no residual hearing in the poorer ear (unaidable) and a hearing loss greater than 30 dB HL for the four frequency average of 500, 1000, 2000, and 4000 Hz in the better ear
- Documentation of requirement for independent functioning (e.g., affects on employment, communication status)

### **PAYMENT RULES**

Medicaid's payment for a BICROS hearing aid will be the lesser of the acquisition cost or Medicaid's maximum allowable amount. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

## **DIGITAL/PROGRAMMABLE HEARING AIDS**

### **STANDARDS OF COVERAGE**

Digital/Programmable hearing aids are a benefit for beneficiaries **under 21 years of age** only when the digital/programmable aid shows superior performance over a conventional analog hearing aid.

**The bilateral hearing loss standards of coverage** for digital/programmable monaural or binaural hearing aids are as follows:

- Bilateral hearing loss documented by an audiogram showing hearing loss of 25 dB HL or greater in both ears using the four frequency average of 500, 1000, 2000 and 4000 Hz **OR**
- Results of a complete diagnostic audiological evaluation (e.g., auditory brainstem response, evoked otoacoustic emissions, soundfield testing, or any combination of these) indicating a hearing loss of 25 dB HL or greater

**The unilateral hearing loss standards of coverage** for digital/programmable monaural hearing aids are as follows:

- Hearing loss of 25 dB HL or greater in the ear to be aided with normal hearing in the better ear
- Speech recognition scores must be greater than 60% in the ear to be aided
- The beneficiary must be receiving hearing impaired services through the school system
- A 30-day trial has been completed and indicates that digital/programmable amplification has been accepted and that auditory skills and learning capacity were enhanced

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## **DOCUMENTATION**

Applicable documentation includes:

- A medical clearance signed and dated by the physician within six months prior to dispensing the hearing aid
- An audiogram and recommendation of the make, model and type of hearing aid, signed and dated by the audiologist within six months prior to dispensing the hearing aid
- Copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping charges

Applicable documentation also includes the following when the acquisition cost of the digital/programmable hearing aid exceeds Medicaid's maximum allowable amount for a comparable conventional analog hearing aid:

- Documentation of superiority of aided thresholds and speech recognition ability in a comparison study of digital/programmable vs. conventional analog aids, including functional gain measures and probe microphone measurements.
- Letters of support from the school system, teacher consultant of the hearing impaired or educational audiologist outlining objective and subjective benefits during a 30-day trial period. Documentation from the parents may be used for supplemental support.
- For infants and young children who are unable to be tested in a comparison study, a letter of justification for advanced technology is required.

### **Unilateral Hearing Loss-**

Applicable documentation also includes the following when a digital/programmable hearing aid is dispensed for unilateral hearing loss:

- Documentation from the educational system that the child is receiving hearing impaired services
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired and/or the educational audiologist that digital/programmable amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial.

## **PRIOR AUTHORIZATION REQUIREMENTS**

PA is required for all digital/programmable hearing aids.

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The following documentation must be submitted with all prior authorization requests for digital/programmable aids:

- MSA-1653-B
- Copy of the manufacturer's invoice showing invoice price, discounts, and shipping and handling charges
- Medical clearance
- Audiogram completed within the past 6 months, signed and dated by the audiologist, and including the recommended manufacturer, model and style

The following additional documentation must be submitted with all prior authorization requests when the acquisition cost of the digital/programmable hearing aid exceeds Medicaid's maximum allowable amount for a comparable conventional analog hearing aid:

- Documentation of superiority of aided thresholds and speech recognition ability in a comparison study of digital/programmable vs. conventional analog aids, including functional gain measures and probe microphone measurements.
- Letters of support from the school system, teacher consultant of the hearing impaired or educational audiologist outlining objective and subjective benefits during a 30-day trial period. Documentation from the parents may be used for supplemental support.
- For infants and young children who are unable to be tested in a comparison study, a letter of justification for advanced technology is required

The following additional documentation must be submitted with all prior authorization requests for digital/programmable hearing aids provided for unilateral hearing loss regardless of acquisition cost:

- Documentation that the ear to be aided has a speech recognition score greater than 60%
- Documentation provided by the educational system that the child is receiving hearing impaired services
- Letters of support from the classroom teacher, teacher consultant of the hearing impaired, and/or the educational audiologist that amplification has been accepted and did enhance auditory skills and learning capacity following a 30-day trial

## **PAYMENT RULES**

Payment for a digital/programmable hearing aid will not exceed Medicaid's maximum allowable amount for a comparable conventional analog hearing aid unless the documentation submitted with the PA request supports the need for the more advanced technology found with a digital/programmable hearing aid. When the need for a digital/programmable hearing aid is provided, the payment will be the acquisition cost for the digital/programmable hearing aid. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

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## HEARING AID SUPPLIES AND ACCESSORIES REPLACEMENT

### STANDARDS OF COVERAGE

The following hearing aid supplies and accessories are considered a benefit, if necessary, at a maximum of:

<u>Item</u>	<u>Maximum</u>
Hearing Aid Dry Aid Kit	2 per year per hearing aid
Hearing Aid Earhook	4 per year per hearing aid
Hearing Aid Superseals	2 per year per hearing aid
Hearing Aid Holster/Huggies	4 per year per hearing aid
Stetheset (Under 21 years old)	1 with initial hearing aid only
Hearing Aid Battery Tester	1 with initial hearing aid only
Hearing Aid Earmold Blower	1 with initial hearing aid only

### DOCUMENTATION

Applicable documentation includes:

- A list of hearing aid supplies/accessories provided to the beneficiary within the past 365 days
- A copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges

### PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization is **not** required for hearing aid supplies and accessories if:

- The sum of all payments for accessories/supplies within the past 365 days is \$40 or less

Prior authorization **is** required for hearing aid supplies and accessories if:

- Any single item is billed with requested payment amounts of over \$40
- The sum of all payments for accessories/supplies billed within the past 365 days is over \$40
- An item exceeds the standards of coverage

Hearing aid supplies/accessories that exceed either the maximum payment limit of \$40 or the standards of coverage **require PA**, and a list of supplies/accessories provided within the past 365 days must be submitted with the MSA-1653-B PA request

### PAYMENT RULES

Medicaid's payment for hearing aid supplies and accessories includes the acquisition cost plus 10%. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

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## REPLACEMENT OF DISPOSABLE HEARING AID BATTERIES

### STANDARDS OF COVERAGE

Medicaid covers the replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 25 batteries per hearing aid per six months. All batteries must be dispensed in the original packaging and must be dispensed at least one year before the expiration date shown on the package. The establishment of a "battery club", where batteries are automatically mailed to a beneficiary, regardless of need, is not allowed.

Hearing Aid Dealers may not bill for replacement of disposable batteries for cochlear implant devices.

### PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization is required for quantities exceeding the standards of coverage. Documentation must accompany the MSA-1653-B PA request to substantiate the need for additional batteries.

### PAYMENT RULES

Medicaid's payment for disposable hearing aid batteries includes the acquisition cost plus 10%. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

## REPLACEMENT EARMOLDS

### STANDARDS OF COVERAGE

Beneficiaries age **12 years and over** who use hearing aids that require custom earmolds are eligible for replacement earmolds every 12 months without prior approval.

Beneficiaries age **3 to 12 years** are eligible for replacement every six months without prior approval.

Beneficiaries **under age 3 years** are eligible for replacement every three months without prior approval.

### PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization is required for replacements exceeding the standards of coverage. Documentation must accompany the MSA-1653-B PA request to substantiate the need for additional earmold replacements.

### PAYMENT RULES

Medicaid's payment for replacement earmolds includes the acquisition cost plus 10%. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

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## HEARING AID REPAIRS AND MODIFICATIONS

### STANDARDS OF COVERAGE

The provider may bill for repairs and modifications only to the most recently dispensed out-of-warranty hearing aid. Repairs will not be covered for “back-up” aids or devices. Services under warranty may not be billed to Medicaid. The amount billed must reflect no more than the actual cost of the repair plus 10%.

### DOCUMENTATION

Applicable documentation includes an itemization of materials used to repair the hearing aid and related labor costs.

### PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization is **not** required for hearing aid repairs and/or modifications if:

- The payments for the repair/modification are less than \$80
- No more than 2 separate repairs/modifications are billed in 365 days

Prior authorization **is** required for hearing aid repairs and/or modifications if:

- The requested payment amount is over \$80
- Separate repairs/modifications are billed over 2 times in 365 days

Repairs that are expected to exceed either the maximum payment limit of \$80 or 2 episodes in 365 days **require prior authorization**. Documentation must be submitted with the MSA-1653-B prior authorization request providing a written estimate of what the repair and/or modifications will be. The estimate should include the materials, labor and shipping costs.

### PAYMENT RULES

Medicaid’s payment for hearing aid repairs/modifications includes no more than the actual cost plus 10%. Actual cost will consist of acquisition cost of materials used for the repair plus related labor costs and actual shipping costs.

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## ALTERNATIVE LISTENING DEVICES

### Alternative listening device (ALD)

Special purpose electro-acoustic device designed to enhance receptive communication (e.g., Pocket Talker).

### STANDARDS OF COVERAGE

Alternative listening devices (ALD) are a benefit for beneficiaries **age 21 or over** under the following conditions:

- No hearing aid has been dispensed to the beneficiary within 3 years
- No ALD has been dispensed to the beneficiary within 3 years
- The beneficiary is residing in a LTC facility
- Patient management of a personal hearing aid is considered unrealistic and/or frequency-specific audiometric data cannot be obtained in each ear
- The ALD is provided for situations involving one-on-one conversation
- The ALD is not designed primarily for television or telephone amplification, theater or classroom use.

### DOCUMENTATION

Applicable documentation includes:

- A letter from the audiologist delineating why a personal hearing aid is inappropriate and the recommended type of ALD
- An audiogram, signed and dated by the audiologist within six months prior to dispensing the device or documentation showing that frequency-specific audiometric data could not be obtained in each ear
- Copy of the manufacturer's invoice showing the ALD model, serial number, invoice price, applicable discounts and shipping charges

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## **PRIOR AUTHORIZATION REQUIREMENTS**

Prior authorization is required for all alternative listening devices. The following documentation must be submitted with the PA request:

- MSA-1653-B
- Copy of the manufacturer's invoice showing invoice price, discounts, and shipping and handling charges
- A letter from the audiologist delineating why a personal hearing aid is inappropriate and the recommended type of ALD
- An audiogram signed and dated by the audiologist within six months prior to dispensing the device or documentation showing that frequency-specific audiometric data could not be obtained in each ear within six months prior to dispensing the device.

## **PAYMENT RULES**

Medicaid's payment for an ALD includes the provider's acquisition cost plus 10%. Acquisition cost will consist of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs. Medicaid will not reimburse providers for a separate dispensing fee for ALDs.